Focus . . . Managed Care Organizations and Quality Indicators

In its drive for accountability in health care, the Missouri legislature in 1997 passed into law House Bill 335. While the law primarily addresses Department of Insurance rules and regulations for health main tenance organizations (HMOs), Section 192.068 directs the Department of Health (DOH) to collect and disseminate data on the quality of care provided by these organizations. Because of this legislation, managed care companies that offer HMO and POS (point- of-service) plans are the focus of a new publication, *Show Me Buyer's Guide: Managed Care Plans*, recently released by the Department of Health.

To assist in the development of the consumer guide, the DOH formed a managed care advisory committee comprised of health care professionals, managed care industry personnel, employers, academics, and other parties interested in health care reform. Thei r mission was to collaborate with DOH in determining the appropriate methodology to fulfill the purposes of the law. Among the tasks of the committee was the selection of quality indicators and other available information that would help Missourians disti nguish among the managed care plans and make comparisons on various aspects of their performance.

To allow for standardized comparisons among plans, the advisory committee elected to use the assessment system established by the National Committee for Quality Assurance (NCQA) -- a private, non-profit organization established in 1991 that has been a leader in the effort to assess, measure and report on the quality of care provided by managed care plans. NCQA has been well received by the managed care industry. Over half of the HMOs in the nation have been involved in the organization's accreditation process and more than three-fourths of Americans enrolled in HMOs are in plans that have been reviewed by NCQA.[1]

In addition to examining the clinical and administrative systems of managed care organizations during the accreditation process, NCQA employs a performance measurement tool to determine if plans actually achieve quality care for their members. Known as the Health Plan Employer Data and Information Set (HEDIS®)*, the tool consists of a set of standardized measures that are designed to allow for reliable comparisons of the performance of managed health care organizations. The measures cover a broad r ange of health issues such as the accessibility and availability of care, patient information about health care choices, effectiveness of the care and treatment provided, members' satisfaction with the care they receive, the reasonableness of the cost of the care, and information about the stability of the plan.

HEDIS Quality Performance Measurements

In 1998, the advisory committee chose a limited number of HEDIS quality indicators that commercial health care plans in Missouri would be required to report. The indicators selected included:

- the percentage of HMO- and POS-enrolled women (ages 52- 62) who had breast cancer screenings within a specified time
- the percentage of diabetics who were referred annually for eye exams
- the percentage of enrollees hospitalized for treatment of certain mental health disorders who received follow-up care within 30 days of discharge
- the hospital readmission rate within one year for selected mental health disorders

Note: HEDIS measures make necessary allowances for age groupings, gender, enrollment status in the plan and other circumstances that might influence the results.

Data on these same measures were required from the Medicare HMOs. As with the commercial plans, the data collection for these measures was subject to a HEDIS audit, however for Medicare HMOs the required audits were performed by NCQA-licensed firms con tracted by the Health Care Financing Administration (HCFA), the government entity responsible for administering the Medicare program.

Because of the specific eligibility qualifications of the Medicaid population in HMOs, the selection of the required quality indicators for the Medicaid plans was done in close collaboration with the Department of Social Services, Division of Medical S ervices. Two quality indicators were selected for reporting by the Medicaid plans: the percentage of women who received appropriate cervical cancer screenings and the percentage of children who received recommended immunizations in a timely manner.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Commercial Managed Care Performance Measures

Commercial managed care plans in Missouri, in general, fell below the national averages reported by NCQA on the selected HEDIS indicators.[2] (See Chart 1) Nation ally, 71 percent of women i n commercial managed care had breast cancer screenings, compared to 66 percent of women enrolled in Missouri commercial managed care plans. In other words, approximately one-third of the women who were eligible to have mammograms or clinical breast examin ations failed to have this type of health screening. The indicator data on diabetes care also yielded a disparity between the national and Missouri results. The national rate for referral of diabetics for eye exams to prevent blindness was 39 percent; Mis souri's average was 28 percent. The NCQA-published national rate for follow-up treatment for patients hospitalized for mental health disorders was 67 percent. In our state, the average rate of follow-up was 57 percent. While patients do have the final res ponsibility to seek these treatments, the health maintenance organizations also have a responsibility to ensure their enrollees are aware of the health care benefits available to them.

Medicare Managed Care Performance Measures

For the indicators on breast cancer screening and diabetic referral for eye exams, the Missouri Medicare managed care plans were comparable to Medicare HMOs across the nation. However for both indicators the Medicare plans outperformed the commerci al plans in the state. Sixty-eight percent of women in the Medicare plans had an appropriately timed breast cancer screening versus 66 percent of commercial enrollees. Forty-two percent of the diabetic patients in Medicare plans were referred for an annua l eye exam, while only 28 percent of diabetic commercial enrollees were referred for this exam. Commercial plans, though, did a better job with follow-up care for members who had been hospitalized because of a mental health diagnosis (57 percent vs. 50 pe rcent) - a measure intended to prevent further

hospitalizations. Perhaps because of the follow-up care provided, the hospital readmission rate for these types of diagnoses was lower for commercial enrollees than for those enrolled in Medicare HMOs (10 per cent vs. 21 percent).

Medicaid Managed Care Performance Measures

Although we have no comparable national data for Medicaid HEDIS indicators, the results for the Missouri Medicaid plans were disappointing. Only one-third of women targeted as eligible for cervical cancer screening received a Pap test during the re porting year. The *Healthy People 2000 (HP 2000)*[3] goal is for 85 percent of women to have this cervical screening procedure, intended to effect early detection and treatment of cervical cancer. The results for childhood immunization rates are also a concern. The *HP 2000* goal is for 90 percent of children under two years of age to receive all of their basic immunizations. Missouri Medicaid plans, in aggregate, achieved only seven percent on this indicato r. However there may be alternative explanations for such a low rate, including the lack of complete medical history and records for the children enrolled in the Medicaid managed care plans. When the DOH's MOHSAIC program is complete, the department will be able to provide the managed care plans standardized data on childhood immunizations in the state. The latter should help to elevate the rates significantly and, at the same time, eliminate the audit requirement for this performance measure.

Birth-Related Performance Measures

Given the availability of birth record files, the DOH was able to compute three of the birth-related HEDIS quality performance measures for both Medicaid and commercial plans, based on supplied enrollee data. The linked records allowed DOH to c alculate the percentage of women who had a prenatal visit in the first trimester of their pregnancy, the percentage who delivered by cesarean section, and the percentage of women who delivered vaginally but who previously had a cesarean section (VBAC). Th e ability of the DOH to match the enrollee and birth record data, and subsequently produce the birth-related performance statistics, reduced the costs to the plans of the HEDIS audits on these measures. It also enabled the use of comparably produced infor mation in the *Buyer's Guide*.

Statewide, commercially enrolled women were more likely than Medicaid enrolled women to have prenatal care in the first trimester (95 percent vs. 68 percent). They also were more likely to have a cesarean section (21 percent vs. 16 percent) and less li kely to have a VBAC (28 percent vs. 36 percent). Nationally, the managed care rates on the birth-related measures were 83 percent for prenatal care and 21 percent for cesarean sections, based on audited data provided to NCQA by the participating plans. (N ote: NCQA data are not available on VBAC rates.) In comparison to the above, the national goals in *HP 2000* are to have at least 90 percent women getting prenatal care in the first trimester and not more than 15 percent delivering by cesarean sectio n.

With the availability of both the birth record data and the managed care enrollment data, it also was possible for the DOH to calculate statewide rates on the birth-related measures for women *not* covered by a managed care plan. (See Chart 2) An analysis of the latter showed that these women were somewhat less likely than commercial managed care plan enrollees to receive early prenatal care (89 percent vs. 95 percent). Although the cesarean rates for non-enrolled women were the same as for commercial enrollees (21 percent), the VBAC rate for this group was somewhat higher (30 percent).

Member Satisfaction

State regulations require that all managed care organizations in the state submit to the DOH the results of a member satisfaction survey. A significant component of quality care information helps consumers and purchasers expand their knowledge about the managed care experience. It also helps the managed care plans to focus on continually improving the health care and customer service provided to their members.

For the 1998 reporting year, commercial plans were required to have member satisfaction surveys conducted by independent vendors certified by NCQA, thereby ensuring that collection protocols and sampling methodologies conformed to the HEDIS standards a nd specifications. The non-commercial plans, however, followed somewhat different data collection protocols. For the Medicaid and Medicare plans, the member satisfaction surveys were administered and processed by their respective funding agencies, DSS and HCFA. Despite the differences in survey protocols, it remained possible to examine comparative information on member satisfaction within each type of plan.

Although the satisfaction levels of commercial plan members in Missouri were at or below the national average analyzed, for most of the questions analyzed, more than four of five enrollees surveyed (84 percent) said they would recommend their plan to o thers. Comparative national statistics on the satisfaction of Medicare HMO enrollees are not available for this report, but nearly half of the Missouri Medicare HMO survey respondents said they were satisfied with the care they received and slightly more than half rated their plan as better than average. There also are no national data on member satisfaction for Medicaid managed care, however the survey results for Missouri indicate that nearly nine of ten Medicaid plan enrollees (88 percent) would recomm end their managed care plan to family and friends.

The 1998 DOH consumer guide should be considered the pilot phase of the report card process on managed care in Missouri. Even so, this first publication provides consumers, purchasers and insurance providers in the state access to comparative informati on that previously has not been compiled. The availability of these data should help consumers and purchasers make more informed health care choices and assist them in their plan selection decisions. While cost, convenience and provider choice are all imp ortant considerations when choosing a plan, any assessment of the "value" of a health plan requires that the quality of care be factored into the equation, as well.

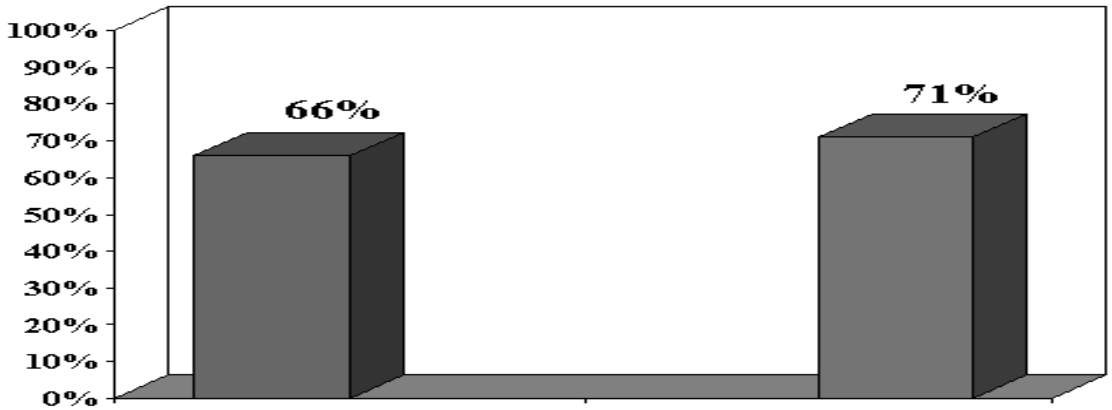
The complete consumer guide booklets cover three separate geographic areas of the state (Central, East and West) and contain additional information about the managed care plans in Missouri, including enrollment statistics and other organization prof ile data. The guide is available for $3.00 from the Department of Health, Center for Health Information Management and Epidemiology, PO Box 570, Jefferson City, MO 65102-0579. Telephone: 573/751-6279. Fax: 573/526-4102. The publication may also be printed or downloaded at no charge from the department's web site: www.health.state.mo.us/

References:

1Information concerning the National Committee for Quality Assurance and HEDIS is based on "What is the National Committee for Quality Assurance?" on the web site of the National Committee for Quality Assurance at www.ncqa.org.

2NCQA national figures are taken from National Committee for Quality Assurance, QUALITY COMPASSTM 1998

3Healthy People 2000 national goals are references from US Dept of Health and Human Services, Public Health Service, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.*



Provisional Vital Statistics for July 1999

Live births increased in July as 6,467 Missouri babies were born compared with 6,274 one year earlier. Cumulative births for the 7- and 12-month periods ending with July also show increases. For January -July, 43,853 births occurred or 1.9 more than during the comparable period in 1998.

Deaths decreased slightly in July as 4,230 Missourians died compared with 4,267 in July 1998. However, cumulative deaths increased for the 7- and 12-month periods ending with July.

The **Natural increase** in July was 2,237 (6,467 births minus 4,230 deaths). The rate of natural increase in July was 5.1 per 1,000 population.

Marriages decreased for all three time periods shown in the table below.

Dissolutions of marriage increased in July, but decreased for the cumulative 7- and 12-month periods ending with July.

Infant deaths decreased for all three time periods shown below. For the 12 months ending with July, the infant death rate decreased from 7.9 to 7.3 per 1,000 live births.

PROVISIONAL RESIDENT VITAL STATISTICS FOR THE STATE OF MISSOURI

Item	July				Jan. July cumulative				12 months ending with July				
	Number		Rate*		Number		Rate*		Number			Rate*	
	1998	1999	1998	1999	1998	1999	1998	1999	1998	1999	1997	1998	1999
Live Births	6,247	6,467	14.0	14.8	43,039	43,853	13.7	13.9	74,227	76,466	13.5	13.7	14.0
Deaths	4,267	4,230	9.5	9.7	31,441	32,819	10.0	10.4	53,262	54,757	10.1	9.8	10.0
Natural increase	2,007	2,237	4.5	5.1	11,598	11,034	3.7	3.5	20,965	21,709	3.5	3.9	4.0

Marriages	4,049	3,854	9.1	8.8	24,829	24,392	7.9	7.7	43,578	43,248	8.3	8.0	7.9
Dissolutions	2,115	2,203	4.7	5.1	14,790	14,280	4.7	4.5	25,424	24,795	4.7	4.7	4.5
Infant deaths	58	45	9.2	7.0	371	332	8.6	7.6	587	558	8.1	7.9	7.3
Population base (in thousands)	...	...	5,439	5,470	...	...	5,439	5,470	...	...	5,386	5,423	5,454

*Rates for live births, deaths, natural increase, marriages and dissolutions are computed on the number per 1,000 estimated population. The infant death rate is based on the number of infant deaths per 1,000 live births. Rates are adjusted to account for varying lengths of monthly reporting periods.

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